Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Disabilities (Adults)

Name of designated centre:	Luchanna
Name of provider:	Resilience Healthcare Limited
Address of centre:	Kerry
Type of inspection:	Unannounced
Date of inspection:	04 September 2018
Centre ID:	OSV-0005677
Fieldwork ID:	MON-0021562

About the designated centre

The following information has been submitted by the registered provider and describes the service they provide.

This designated centre is located in a rural but accessible location, a short commute from the busy local town; transport is provided. The provider aims to provide each resident with a safe and homely environment and health and social care services that enhance individual quality of life. Residential and shared care (shared with home) services are provided to a maximum of four residents. The centre is staffed continuously by a team of social care staff supported by the team leader and the person in charge. The premises is located on a spacious site, is well maintained and suited to residents' individual and collective needs.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

How we inspect

To prepare for this inspection the inspector or inspectors reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
04 September 2018	09:30hrs to 16:30hrs	Mary Moore	Lead

Views of people who use the service

Three residents receive support and services; two residents were in the centre on the day of inspection. The inspector met with the residents prior to their departure in the morning for their day service, on their return in the evening and during the day when they returned briefly with staff. Residents do not communicate verbally and choose to utilise a variety of communication methods. Routine is also very important to residents and if disrupted can be a source of anxiety; this was respected by the inspector. Residents engaged for example through physical gesture and facial expression. Throughout the day residents communicated comfort and security in their environment, with the staff on duty and with their routines.

Capacity and capability

There was a clear system of management and a commitment to providing each resident with a safe quality service appropriate to their needs; the centre was adequately resourced to achieve this objective. However, the provider had not completed an unannounced review of the service since it commenced operation in January 2018. This resulted in a lack of oversight to facilitate ongoing improvement and a failure self-identify failings and ensure that there was a plan to address failings identified by such a review.

Staff described systems that supported good governance such as almost daily contact between the team leader and the person in charge and formal meetings of the management team. These meetings were described as a good source of learning on the day to day management of a centre. Staff were supported in their practice by a formal system of staff supervision. There was a dedicated out-of-hours management resource available to staff.

The inspector found that staffing levels and arrangements were adequate to meet the number of and the assessed needs of the residents. The aim was to ensure that residents had independence but were also safe and provided with the staff support that they needed to enjoy meaningful engagement on a daily basis. Records seen indicated that a team of regular staff were employed including a core group of relief staff from the providers own resources; this ensured familiarity and consistency of support for residents.

Staff training records were reviewed; overall staff had completed mandatory training in safeguarding, fire safety and responding to behaviours that challenged; attendance at refresher training was monitored. Additional training supported good practice and included infection prevention and control, medicines management, first-

aid and epilepsy awareness.

A small sample of staff files was reviewed; this review indicated good recruitment practice with evidence of appropriate knowledge and experience for the role and vetting including references and Garda clearance.

In relation to monitoring the quality and safety of the service staff had completed a range of audits such as medicines management, hand hygiene practice, environmental hygiene and the submission of notifications to HIQA (Health Information and Quality Authority) audits; the audits reported a satisfactory level of compliance in these areas.

However, the provider had not complied with the regulatory requirement to undertake an unannounced review of the quality and safety of the care and support provided in the centre at least once every six months; the centre was operational since early January 2018. This review would have provided the opportunity for the provider to self-identify the failings identified by this HIQA inspection.

Regulation 14: Persons in charge

The person in charge worked full-time and had the qualifications, skills and experience necessary to manage the designated centre. The person in charge facilitated the inspection with ease and had sound knowledge of the residents and their needs and of the general operation and administration of the designated centre.

Judgment: Compliant

Regulation 15: Staffing

Staffing levels and arrangements were appropriate to the assessed needs of the residents. Residents received continuity of care and supports.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had completed mandatory training within the specified timeframes; attendance at baseline and refresher training was monitored. Staff had also completed training that supported them to respond appropriately and safely to resident's needs.

Judgment: Compliant

Regulation 23: Governance and management

The provider had failed to comply with the regulatory requirement to undertake an unannounced review of the quality and safety of the care and support provided in the centre at least once every six months; the centre was operational since early January 2018.

Judgment: Substantially compliant

Regulation 24: Admissions and contract for the provision of services

Contracts that set out the services, support, care and welfare of the resident in the centre were in place. However, one contract while signed by the resident's representative was not signed on behalf of the provider.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

The complaints procedure was displayed in the main entrance hallway; staff understood how complaints were managed. Staff advised that no complaints had been received since the centre opened in January 2018. The inspector reviewed associated records such as daily communication with residents' representatives and records of personal planning meetings; there was no evidence that concerns or dissatisfaction had been raised.

Judgment: Compliant

Quality and safety

This inspection found that residents were in receipt of a safe, quality service that responded to individual needs. However, areas requiring improvement were identified and included procedures for the effective evacuation of residents from the designated centre.

The provision of care and support was based on a comprehensive assessment of resident ability, needs and requirements completed prior to their admission in early 2018. A detailed plan of support was devised based on the findings of the assessment, recommendations made by the multi-disciplinary team and staff knowledge of residents as this increased. The sample of support plans reviewed by the inspector was presented so as to provide a clear integrated picture of each resident, the areas where support was required and what that support was. Staff spoken with described these supports and provided assurance that the plan guided practice on a daily basis.

The plan included resident's personal goals and objectives; residents, their representatives, and as appropriate other stakeholders such as other service providers were consulted with, participated in and contributed to the development and review of the plan. The resident's participation was enhanced by the reported use of a visual presentation. However, persons responsible, the actions taken or to be taken to progress personal goals and objectives was not clearly evidenced. The person in charge had developed a tool for this but it was not evidenced in practice; this is addressed in governance in the context of oversight.

The inspector did find that residents had access to a broad range of meaningful activities and community engagement; this was evident from records seen and from speaking with staff. Residents attended a day service delivered by the provider from a nearby location. Engagement was focussed on meeting and promoting resident general welfare and development and was predominantly sourced and delivered in the local community. The list of opportunities that residents enjoyed was extensive and it was evident to the inspector that residents were enabled to lead their lives in as fulfilling a way as possible.

This was facilitated by the management of risk so as to safely support resident independence and engagement in the community and in their chosen activities. The person in charge maintained a comprehensive register of centre specific, work-related and resident specific risks, their assessment and management. Controls were implemented that reduced the level of risk; staff described these controls such as increased staffing for community based activities.

Residents themselves chose how these wished to communicate and used a variety of communication methods on a daily basis with staff including pictorial systems of communication, social stories (a learning tool that describes a social situation and how to respond to it), physical gestures and computer devices. This multi-faceted approach to communication was understood and facilitated by staff.

Routines were informed by residents needs and choices, for example as established through the personal planning process discussed above and also through ongoing consultation with residents. The inspector reviewed the records of meetings

convened on average weekly where staff and residents discussed meal choices and weekly activities. The individualised nature of the service was reflected in the manner in which staff recorded the individual choices as made by each resident and how these were established, for example using a suite of representative pictures. Improving the consistency of the records and broadening the scope of the agenda was discussed at verbal feedback.

Residents did have some healthcare needs that required monitoring and care to ensure they enjoyed good health. These healthcare needs were established and the required support and care was clearly set out for staff in the support plan. The inspector saw that staff monitored resident well-being, were attuned to changes and sought medical advice and review from the GP (General Practitioner). Residents were supported to access other required services such as neurology, speech and language therapy (SLT), psychiatry and behaviour support.

Medicines were prescribed in the context of maintaining health. While some minor recommendations were made such as refining stock management systems, overall the inspector found that the provider had medicines management systems that supported safe practice. For example all staff had completed training; records were maintained of all medicines administered and disposed of; stock balances were checked daily to confirm that medicines had been administered as prescribed.

Residents did at times present with behaviours that required responsive management. Staff monitored and analysed behaviours so as to identify possible causes and solutions; the approach was therapeutic and supported by input from the behaviour therapist. Staff spoken with confirmed that they were to commence further training on understanding and responding to behaviours and their hope that this would further support positive outcomes for residents. Risk control measures and staff response sought to promote resident safety and quality of life, for example changing plans or activities when these were clearly causing anxiety.

The provider had measures aimed at protecting residents from harm and abuse. Staff attended safeguarding training and while two staff had yet to attend, this training was scheduled and imminent. The risk of harm and abuse was assessed and control measures identified; for example two staff on duty at all times. Residents' representatives were consulted and communicated with at times daily. Residents' needs were described by staff as compatible in relation to shared space and routines. The person in charge described admission procedures that recognised the need to protect residents and preserve this compatibility in relation to any proposed admission. However, it was discussed at feedback how the provider could explore the potential for supporting each resident to develop their understanding of and the skills needed for self-care and protection.

While the provider had comprehensive fire management systems, the provider failed to demonstrate that it had adequate procedures for the evacuation of residents. Fire management systems; that is the integrated fire detection system, emergency lighting and fire fighting equipment were appropriately inspected and tested. There was evidence of fire resistant doors and clearly designated escape routes. Staff had completed fire safety training and convened simulated evacuation drills with

residents. However, the record of one such drill undertaken in April 2018 stated that it had taken 11 minutes to evacuate three residents and ten minutes to evacuate one resident. There was no evidence of action taken to address this so as to improve on the evacuation procedure and time in the context of the resident's needs. The next evacuation drill was convened in June 2018 and while staff recorded that all residents walked out of the building, the time of the evacuation, the time taken to evacuate, or how this particular resident responded on this occasion were not recorded.

Regulation 10: Communication

There was evidence of a broad understanding of how residents communicated and respect for comprehension where expressive ability was limited. Staff and residents used a variety of tools to support effective communication.

Judgment: Compliant

Regulation 13: General welfare and development

Residents were facilitated to maintain personal relationships in accordance with their wishes. The provider was proactive in identifying and facilitating for residents initiatives for participation in the wider community. Each resident had opportunity for new experiences, social participation and recreation. Access was determined by individual needs, abilities, interests and choices.

Judgment: Compliant

Regulation 17: Premises

The inspection was unannounced. The premises was visibly clean, organised but comfortable and homely. The premises was well maintained and met residents individual and collective needs.

Judgment: Compliant

Regulation 18: Food and nutrition

Residents dietary requirements were clearly laid out in the support plan and staff spoken with were cognisant of them. Staff sought to support residents to make healthy lifestyle choices and used monitoring tools such as food diaries and regular measurement of body weight. There was a good stock of fresh, varied food products in the centre; staff were seen to freshly prepare the main meal of the day and establish resident choice in relation to the fluids on offer.

Judgment: Compliant

Regulation 26: Risk management procedures

Risk management policies and procedures and risk assessments were in place for dealing with situations where resident and/or staff safety may have been compromised. The approach to risk management was individualised and supported responsible risk taking as a means of enhancing the quality of life while keeping residents safe from harm.

Judgment: Compliant

Regulation 28: Fire precautions

Based on the records seen of simulated drills the provider failed to demonstrate that it had adequate arrangements for evacuating each resident, where necessary in the event of fire.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

The provider had medicines management policies and procedures; staff had completed the relevant training. Based on the records seen on inspection staff adhered to the procedures for the safe administration of medication and medication was administered as prescribed. Records were kept to account for the management of medicines including their receipt, administration and disposal.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Each resident had a personal plan that detailed their needs and outlined the supports required to maximise their well-being, personal development and quality of life. The plan was developed and reviewed in consultation with the resident and their representative as appropriate.

Judgment: Compliant

Regulation 6: Health care

Staff assessed, planned for and monitored residents healthcare needs. Each resident has access to the range of healthcare services that they required.

Judgment: Compliant

Regulation 7: Positive behavioural support

There was evidence of a positive approach to responding to behaviour and plans that detailed how therapeutic interventions were implemented; the plan was informed by input from the behaviour therapist.

Judgment: Compliant

Regulation 8: Protection

The provider had measures in place to ensure that residents were protected from harm and abuse.

Judgment: Compliant

Regulation 9: Residents' rights

Residents were supported to safely exercise independence, choice and control in their daily routine. There was an individualised approach to establishing resident choice and preference. The provider was aware of and respected resident capacity to make decisions about their daily lives.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Admissions and contract for the provision of services	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Luchanna OSV-0005677

Inspection ID: MON-0021562

Date of inspection: 04/09/2018

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The Service Provider has carried out an unannounced internal inspection on the 17th of December 2018. The person carrying out the unannounced visit will furnish the service with the report and any compliance plan before the end of 2018. The Service Provider going forward will ensure that an unannounced visit will be carried out as per Regulations.	
Regulation 24: Admissions and contract for the provision of services	Substantially Compliant
Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services: The Service Manager on the date of Inspection 04/09/2108 signed off on the Service User Contract outstanding for service representative.	
Regulation 28: Fire precautions	Not Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: All staff are Fire Safety trained. All staff attended a Team Meeting on the 25th of September 2108 and fire drill training by Team Lead and Service Manager was completed each staff member completed a fire drill practice and filled in the fire drill template. All staff are now proficient in completing fire drills and filling the recording template.	

Weekly fire alarm tests are carried out and all staff have an opportunity to complete this task. Monthly fire drills are completed and all staff have an opportunity to carry out this task.
A PEEP is in place for all service users and a Risk Assessment (R/A) is in place for all service users and reviewed regularly. R/A reviewed on the 5th of September to reflect one S/U who did not leave the building. Drill carried out on the 30th of October when S/U did evacuate but only after the alarm was switched off. Reviewed R/A on the 30th of October identified use of IPad as motivator for S/U and extra fire drills to be carried out reviewed PEEP to reflect same. Fire Drill set for December 20th and Team Lead to review outcome relating to all service users leaving the building and ensure follow up with R/A and PEEPS.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.	Substantially Compliant	Yellow	31/01/2019
Regulation 24(3)	The registered provider shall, on admission, agree in writing with each resident, their representative	Substantially Compliant	Yellow	04/09/2018

	where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.			
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Not Compliant	Orange	25/09/2018